Stockwell PHYSICAL THERAPY

Patient Health History

Name_____ Referring Provider_____

Primary Care Physician _____ Date of Injury/Onset of symptoms_____

Date of last Physician's visit _____ Date of next Physician visit_____

Employer _____ Occupation _____

Mechanism of injury or how accident/injury occurred_____ Work Related? Yes or No

Did you have surgery for this injury/accident? _____ When? _____

Type of surgery _____

Medications_____

Allergies_____

Have you had physical therapy before for this injury/condition? _____

What was done for treatment? _____

Have you had tests (please circle all that apply): XRAY, CTSCAN, MRI, OTHER _____

What is your current Pain Level (1-10) scale (0=no pain, 10=Extreme pain)? _____

Do you currently have or have had a history of the following?

CANCER	YES or NO	HIGH BLOOD PRESSURE	YES or NO
PACEMAKER	YES or NO	INCONTINENCE	YES or NO
ARTHRITIS	YES or NO	PELVIC PAIN	YES or NO
HEART DISEASE	YES or NO	BACK PAIN	YES or NO
HEART SURGERY	YES or NO	JOINT PROBLEMS	YES or NO
DIABETES	YES or NO	SEIZURES	YES or NO
HEADACHES	YES or NO	SHINGLES	YES or NO
SWELLING	YES or NO	CIRCULATION ISSUES	YES or NO
OSTEOPOROSIS	YES or NO	INFECTIONS	YES or NO
HERNIA	YES or NO	MULTIPLE SCLEROSIS	YES or NO
HEARING LOSS	YES or NO	PARKINSON'S DISEASE	YES or NO
HEAD INJURY	YES or NO	THYROID PROBLEMS	YES or NO
VISION LOSS	YES or NO	LIVER PROBLEMS	YES or NO
CONSTIPATION	YES or NO	KIDNEY PROBLEMS	YES or NO
ANXIETY	YES or NO	FRACTURES	YES or NO
WEIGHT LOSS	YES or NO	WEIGHT GAIN	YES or NO
WEAKNESS	YES or NO	DIFFICULTY SLEEPING	YES or NO
DEPRESSION	YES or NO	JOINT REPLACEMENT	YES or NO
TUBERCULOSIS	YES or NO	EMOTIONAL PROBLEMS	YES or NO
COLD SENSITIVITY	YES or NO	HEAT SENSITIVITY	YES or NO
NUMBNESS	YES or NO	SCIATICA	YES or NO

Are you or could you be pregnant? Yes or No

Do you have any other medical history, which may prohibit you from exercise or physical therapy?

_____

What are your goals for Physical Therapy? _____

_____

Patient Signature: _____ Date: _____